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## Abusing the Patient: Medicare Fraud and Abuse and Hospital-Physician Incentive Plans

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## ABUSING THE PATIENT: MEDICARE FRAUD AND ABUSE AND HOSPITAL-PHYSICIAN INCENTIVE PLANS

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The Medicare<sup>1</sup> prospective payment system (PPS),<sup>2</sup> enacted in 1983, fundamentally restructured the method of government reimbursement to hospitals for care of Medicare inpatients.<sup>3</sup> The PPS uses diagnosis related groups (DRGs)<sup>4</sup> to fix amounts for reimbursing hospitals for treatment provided under the Medicare system. Upon admitting a Medicare patient, a hospital assigns her to a particular DRG. The DRG assigned entitles the hospital to receive a predetermined amount for that inpatient's care. Thus, the payment does not vary according to the severity of the patient's illness, the length of the patient's stay, or the unique characteristics of the particular patient's case.<sup>5</sup> If a hospital can treat and discharge a patient at a cost less than the set rate of reimbursement, the hospital will make a profit on that

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1. The Medicare provisions of the Social Security Act provide medical benefits for qualified persons. 42 U.S.C. §§ 1395-1395zz (1982 & Supp. III 1985).

2. The PPS went into effect October 1, 1983. The Department of Health and Human Services administers the program. 42 C.F.R. pt. 412 (1986).

3. See *infra* notes 10-23 and accompanying text.

4. DRGs originally categorized a patient into one of 467 groups, based upon such factors as patient age, principal diagnosis, complicating conditions, and type of surgery required. STAFF OF THE SENATE COMM. ON FINANCE, BACKGROUND INFORMATION RELATING TO MEDICARE HOSPITAL PROSPECTIVE PAYMENT PROPOSAL REPORTED TO CONGRESS BY SECRETARY RICHARD S. SCHWEIKER 3 (1983) [hereinafter SENATE FINANCE COMM. PPS REPORT], reprinted in 1 *Hospital Prospective Payment System: Hearing Before the Subcomm. on Health of the Senate Comm. on Finance*, 98th Cong., 1st Sess. 3, 6 (1983) [hereinafter 1 PPS Hearing]; 42 C.F.R. § 412.60(c)(1) (1986). For the most recent list of 473 DRGs, see Medicare Program; Changes to the Inpatient Hospital Prospective Payment System and Fiscal Year 1987 Rates, 51 Fed. Reg. 31,454, 31,561-74 (1986).

5. 42 U.S.C. § 1395ww(d)(5)(A)(i)-(ii) (Supp. III 1985) allows for additional reimbursement where the length of a patient's stay exceeds the calculated mean length-of-stay for all patients with a particular diagnosis by a specified number of days or by a fixed number of standard deviations, whichever is fewer. Also, if charges exceed the DRG reimbursement by a fixed dollar amount or by a fixed multiple of the PPS rate to be determined by the Secretary of Health and Human Services, whichever is greater, additional reimbursement is possible. 42 C.F.R. § 412.80(a) (1986).

patient. If not, the hospital breaks even or must absorb any costs above the reimbursement rate.<sup>6</sup>

Hospitals have developed several strategies for maintaining their financial position under the PPS. These include educating physicians on the costs of patient care<sup>7</sup> and engaging in joint ventures.<sup>8</sup> This Note focuses on a third strategy, hospital-physician incentive plans.

Incentive plans encourage physicians to minimize hospital utilization of ancillary services and decrease length-of-stay for Medicare inpatients. By giving the participating physician financial rewards for reducing patient care costs, the plans offer the physician a significant stake in the cost-containment process. This Note examines the desirability of using incentive plans under the PPS. The Note argues that incentive plans are inappropriate cost-containment measures because they violate the Medicare fraud and abuse provisions<sup>9</sup> and encourage abusive practices that clearly outweigh any financial benefits that result from their use.

Part I provides a background discussion of the PPS, DRGs, and incentive plans. Part II focuses on the fraud and abuse provisions of the Medicare statute and argues that incentive plans violate the plain language of the statute, which prohibits any knowing and willful remuneration for the inducement of referrals. Part III concentrates on the fraudulent and abusive practices that incentive plans encourage. The plans frustrate legislative intent because they encourage practices that subvert the cost-containment purposes of the PPS and have an adverse effect on patient care.

## I. IMPLEMENTATION OF THE PROSPECTIVE PAYMENT SYSTEM AND COST CONSCIOUSNESS

Prior to 1983, Medicare reimbursed hospitals for inpatient care according to the actual reasonable cost of services ren-

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6. 42 C.F.R. § 412.1(a) (1986); see *infra* notes 17-23 and accompanying text.

7. For descriptions of various programs of physician education, see Berger, *Physician Involvement in Hospital Cost Control: Leaders in the Field Talk About Their Programs*, HOSP. F., Mar.-Apr. 1983, at 17.

8. See Carpenter, *Finding the Shoe that Fits: Opportunities in the Marketplace of PPOs, HMOs, and DRGs*, HOSP. F., Sept.-Oct. 1984, at 14; Ellwood, *When MDs Meet DRGs: Physicians Searching for a Response to Prospective Pricing May Find Hospitals Their Best Allies*, HOSPITALS, Dec. 16, 1983, at 62, 62-64, 66; Richards, *Nothing Ventured, Nothing Gained*, HOSP. MED. STAFF, Jan. 1985, at 5.

9. 42 U.S.C. § 1395nn (1982 & Supp. III 1985); see *infra* note 47.

dered.<sup>10</sup> Congressional amendments to the Medicare statute in 1983,<sup>11</sup> however, providing for prospective reimbursement, drastically altered the method of reimbursing hospitals for care of these Medicare patients.<sup>12</sup>

### A. Prospective Payment

The purpose of the PPS was to contain burgeoning health care costs.<sup>13</sup> As the number of elderly patients qualifying for Medicare increased in recent years,<sup>14</sup> and as medical costs skyrocketed,<sup>15</sup> the Medicare system faced serious financial difficulties and even possible insolvency.<sup>16</sup> In 1983, Congress enacted the PPS as one possible solution. An integral part of that system was the DRG.

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10. *Id.* § 1395ww (1982) (amended 1983).

11. Social Security Amendments Act of 1983, Pub. L. No. 98-21, tit. VI, 97 Stat. 65, 149-72 (codified at 42 U.S.C. § 1395ww (Supp. III 1985)).

12. See *supra* notes 1-6 and accompanying text.

13. GENERAL ACCOUNTING OFFICE, INFORMATION REQUIREMENTS FOR EVALUATING THE IMPACTS OF MEDICARE PROSPECTIVE PAYMENT OF POST-HOSPITAL LONG-TERM-CARE SERVICES: PRELIMINARY REPORT 1 (1985), reprinted in *Sustaining Quality Health Care Under Cost Containment: Joint Hearing Before the House Select Comm. on Aging and the Task Force on the Rural Elderly of the House Select Comm. on Aging*, 99th Cong., 1st Sess. app. at 102, 102 (1985) [hereinafter *Joint Hearing on Quality Health Care*]; see also Matsui, *Medicare Payment Policy Needs Corrections*, 254 J. A.M.A. 2454 (1985) (member of Congress explaining his reasons for supporting a pause in the transition to national DRG rates).

14. See O. Hatch, *Health Care Costs: A Discussion Paper*, reprinted in *Health Care Cost: Defining the Issues, 1983: Hearings Before the Senate Comm. on Labor and Human Resources*, 98th Cong., 1st Sess. 3, 9-10 (1983) [hereinafter *Health Care Cost Hearings*]; see also A. SORKIN, *HEALTH CARE AND THE CHANGING ECONOMIC ENVIRONMENT* 56 (1986).

15. Expenditures for health care currently represent over one-tenth of the gross national product, more than double the comparable fraction in 1950. A. SORKIN, *supra* note 14, at 5, 6, Table 2-1. Federal expenditures through the Medicare and Medicaid programs increased an average of 17% per year between 1968 and 1983. *Id.* at 72; see H.R. REP. NO. 404, 96th Cong., 1st Sess., pt. 1, at 1-2 (1979); see also SENATE FINANCE COMM. PPS REPORT, *supra* note 4, at 3 ("In FY 1967, medicare paid \$3.2 billion for hospital services; in FY 1983, medicare will pay over \$37 billion. Medicare expenditures for hospital care have increased 19 percent per year during the last 3 years."), reprinted in 1 PPS Hearing, *supra* note 4, at 5. Richard Schweiker, Secretary of Health and Human Services, projected that Medicare expenditures under cost-based reimbursement for hospital services would reach \$44.7 billion in 1984 and \$58.4 billion in 1985. 1 PPS Hearing, *supra* note 4, at 17, 20. Within the health care sector, hospital costs increase most rapidly, primarily due to the costs of inputs, which include food, labor, and supplies, the basic hotel services a hospital provides. A. SORKIN, *supra* note 14, at 73.

16. *Health Care Cost Hearings*, *supra* note 14, at 33 (statement of Margaret Heckler, Secretary of Health and Human Services, that the Medicare Hospital Insurance Trust Fund will be insolvent in 1990 despite the PPS); A. SORKIN, *supra* note 14, at 53-56 & Tables 4-3, 4-4.

## B. Diagnosis Related Groups

Department of Health and Human Services regulations implemented DRGs, a key element in the new system.<sup>17</sup> Instead of reimbursement on a cost basis, DRGs reflect the average cost of care for patients with a particular diagnosis.<sup>18</sup> The Health Care Financing Administration (HCFA) calculates DRGs on the basis of the average cost of care per diagnosis.<sup>19</sup> The assigned DRG establishes a fixed price for the total treatment rendered by an acute care facility<sup>20</sup> to a Medicare inpatient. HCFA expects most hospitals, with some effort expended towards cost containment, to break even on the aggregate costs of caring for their Medicare inpatients.<sup>21</sup>

Under the PPS, a hospital earns a profit only if it discharges the patient at a cost lower than the DRG rate of reimbursement for that particular patient's illness. Thus, DRGs encourage acute care facilities to decrease spending for care of all Medicare patients to balance the expense of the uncompensated longer stays. If a Medicare patient stays in the hospital longer and incurs more charges than allowed by the assigned DRG, the hospital will suffer a loss.<sup>22</sup> Thus, the PPS allows a hospital to break even, make a profit, or suffer a loss on care provided to any particular Medicare patient.

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17. 42 C.F.R. §§ 412.60-.63 (1986). DRGs are modeled upon a system first developed at Yale University. R. BUCHANAN & J. MINOR, *LEGAL ASPECTS OF HEALTH CARE REIMBURSEMENT* 31 (1985).

18. 42 U.S.C. § 1395ww(d)(2)-(4) (Supp. III 1985). The actual dollar value assigned to any particular DRG will vary from one hospital to another as the Health Care Financing Administration (HCFA) takes into account such variables as geographic location and area wage levels. 42 C.F.R. § 412.63(g)-(h) (1986).

19. Congress recognized that under the PPS, some patients would be treated at a cost less than the DRG rate and some would not. The basic idea was to give hospital management an incentive to control costs. 1 *PPS Hearing*, *supra* note 4, at 18 (statement of Richard S. Schweiker, Secretary of Health and Human Servs.).

20. The PPS exempts certain hospitals—psychiatric hospitals, rehabilitation hospitals, children's hospitals, and hospitals in which the average length-of-stay is greater than 25 days—from its coverage. In addition, DRGs do not cover distinct portions of a hospital constituting psychiatric or rehabilitation units. 42 U.S.C. § 1395ww(d)(1)(B) (Supp. III 1985). As a result, Medicare reimburses these hospitals, or portions of hospitals, on a reasonable cost basis. 42 C.F.R. § 412.22(b) (1986).

21. See Medicare Program; Prospective Payments for Medicare Inpatient Hospital Services, 48 Fed. Reg. 39,752, 39,805 (1983).

22. For instance, the average national DRG payment rate for a hip replacement without complications in 1983 was \$4500. 1 *PPS Hearing*, *supra* note 4, at 49 (statement of Richard S. Schweiker, Secretary of Health and Human Servs.). A hospital, reimbursed at this rate, would receive \$4500 for treating a hip replacement patient, regardless of actual cost.

DRG reimbursement encourages hospitals to develop in-house cost-containment measures. If higher-cost hospitals do not make a profit or at least break even on patients insured through Medicare, they face serious financial difficulties or insolvency.<sup>23</sup> The amount of services provided to patients is key to controlling costs.

### C. Hospital-Physician Incentive Plans

Hospitals provide the equipment and manpower necessary for physicians to care for patients, but the physician orders the variety of services provided each patient.<sup>24</sup> Because doctors control the type and quantity of care administered, they determine whether a hospital will make or lose money under the PPS on any given Medicare patient.<sup>25</sup> Physicians' decisions regarding patient discharges and use of ancillary services, such as laboratory work, x-rays, and other diagnostic testing, affect the hospital's ability to break even or earn a profit under the PPS. Thus, hospitals' efforts at cost containment depend on the cost-effective behavior of their physicians.<sup>26</sup> The PPS does not encompass

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23. By one commentator's estimation, a majority of the country's hospitals achieved record profits in the first quarter of 1985. Eighteen percent of all hospitals are, however, suffering losses. Lefton, *Hospitals Score Record Profits Under DRGs*, Am. Med. News, Aug. 9, 1985, at 1, col. 1. Donald Wegmiller, chairman-elect of the American Hospital Association (AHA), predicted that one-half of that 18%, or over 500 of 5800 hospitals in the country, will close in the next few years. *Id.* But see Frederick, *How You'll Feel the Money Squeeze on Hospitals*, MED. ECON., Feb. 4, 1985, at 117 (denying the claim that substantial numbers of hospitals are facing bankruptcy under the DRGs); Tichon, Krieger, Chinn, Volk & Robinow, *Medicare: Do DRGs Diminish the Quality of Care?*, 8 WHITTIER L. REV. 427, 430 (1986) [hereinafter *Do DRGs Diminish the Quality of Care?*] (transcript of panel discussion presented at the Fifth Annual Whittier Health Law Symposium, Whittier College School of Law, Mar. 14, 1986) (asserting that hospitals are making more money under the PPS than they did under cost-based reimbursement).

24. See, e.g., H.R. REP. NO. 404, 96th Cong., 1st Sess., pt. 1, at 69 (1979) (dissenting views on the favorable reporting out of the Hospital Cost Containment Act of 1979); Mushlin, *Measuring Cost and Quality of Care Under Prospective Reimbursement*, HOSP. MED. STAFF, June 1984, at 17.

25. For example, if a physician treating a patient for a hip replacement, see *supra* note 22, treated the patient at a cost to the hospital of less than \$4500, the hospital would make a profit. On the other hand, if the cost of the various procedures together with the cost of room and board exceeded \$4500, the hospital would have to absorb the loss. Cf. Mariner, *Diagnosis Related Groups: Evading Social Responsibility?*, 12 LAW MED. & HEALTH CARE 243 (1984) (suggesting that physicians are inappropriate decisionmakers for health care rationing).

26. "[E]fficient hospital operation requires close cooperation between hospital administrators and physician staff. . . . [I]t is the physician who makes most of the decisions on patient care. A hospital will not be able to live within Medicare's prospective payment unless its physicians are willing to economize." R. Rubin, in *DRGs—What's Next?* Two

physician reimbursement.<sup>27</sup> Instead, Medicare reimburses physicians on the basis of reasonable, customary, and prevailing charges.<sup>28</sup> Under this system, physicians receive what Medicare deems appropriate compensation for the services provided.

To promote conservative use of facilities, some hospitals have devised plans that encourage physicians to practice in accordance with the DRG rates.<sup>29</sup> These incentive plans give physicians a greater personal financial stake<sup>30</sup> in the cost-containment process and provide an incentive for them to keep patient care costs down. Under one form of hospital-physician incentive plan, when a physician treats a patient at a cost below the DRG rate of reimbursement, the physician will receive a share of the hospital's profits on that patient.<sup>31</sup>

Hollywood Community Hospital<sup>32</sup> recently implemented such a plan. Under Hollywood Community's plan, the hospital, when

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Views 7 (text of seminar sponsored by the Mount Sinai School of Medicine, Department of Health Care Management (1984)) (copy on file with U. MICH. J.L. REF.); see Ellwood, *supra* note 8; Jessee & Suver, *Physicians and DRGs: Survival Under PPS*, HOSP. MED. STAFF, Apr. 1984, at 2-3; Richman, *Physician Incentive Plan Study May Give Guidance*, MOD. HEALTHCARE, July 19, 1985, at 48.

27. Congress has considered a system similar to the PPS to govern physician reimbursement. Lundberg, *How Should Physicians Be Paid?*, 254 J. A.M.A. 2638 (1985).

28. 42 C.F.R. §§ 405.501-.508, .551 (1986). See A. SORKIN, *supra* note 14, at 48-49, for a brief discussion of physician reimbursement under Medicare.

29. An additional reason for the plans is that hospitals, now competing for physicians in order to increase revenues, are striving to attract the best doctors possible. See Richards, *supra* note 8, at 9. The financial attractiveness of incentive plans is one way to draw those physicians who can make the most money for the hospital. See A. SORKIN, *supra* note 14, at 83-84.

30. Many physicians, such as surgeons, rely on hospitals for their practice and livelihood. Ellwood, *supra* note 8, at 62-63.

31. This type of incentive plan rewards each physician on an individual basis. Each physician's additional compensation for cost-effective behavior is determined per patient. Other hospitals could implement plans on other bases. For example, hospitals could reward physicians according to the hospital's profits on all of the particular physician's patients. The form of incentive could also vary. The hospital may choose to reward her with better equipment, see Chenen, *Prospective Payment Can Put You in Court*, MED. ECON., July 1984, at 134, 141, or decreased rental rates on office space, see A. SORKIN, *supra* note 14, at 89.

Still other plans may reward the individual physician on her own performance or a group of physicians for their overall cost-effective behavior. See Note, *The Medicare Rx: Prospective Pricing to Effect Cost Containment*, 19 U. MICH. J.L. REF. 743 (1986) (advocating an indirect, aggregate approach to physician incentives). Distinctions among incentives make little difference in the analysis of the fraud and abuse problem, see *infra* Part II, except perhaps in the degree to which abuse is encouraged, and this Note will not differentiate among them.

32. Located in Hollywood, California, Hollywood Community Hospital is part of the Paracelsus Healthcare Corp. (Pasadena, California) chain. Richman, *supra* note 26, at 48. As of July 1985, 12 of the Paracelsus group of 14 hospitals had implemented similar plans. *Id.* A "good number" of physicians participate in the Hollywood Community incentive plan. *Id.*

it discharges a Medicare patient, calculates the retail charges, including room, board, and other charges, it would have billed had the patient been privately insured or self-paying. If a Medicare DRG payment exceeds seventy-five percent of what the hospital would have charged a private patient, the attending physician, who has chosen to participate in the program, receives a percentage of the excess over that seventy-five percent.<sup>33</sup>

The purpose of Hollywood Community's program was to encourage its physicians to be more cost-conscious while providing quality care.<sup>34</sup> The hospital expected to achieve cost savings by encouraging physicians to decrease patient length-of-stay and to use fewer ancillary services. Hollywood Community anticipated that the "Savings Program" would not compromise the quality of care given in the institution.<sup>35</sup> Nevertheless, the Department of Health and Human Services Regional Inspector General<sup>36</sup> is investigating the effects of the Savings Program on patient care.<sup>37</sup>

Incentive plans represent one of the first efforts at profit sharing<sup>38</sup> in the health care industry. In the past, health care providers avoided profit-sharing arrangements primarily because physicians consider the practice unethical.<sup>39</sup> The American Medical

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33. The formula for Hollywood Community's incentive payments is as follows:

If the Amount of the  
Medicare Payment Falls  
within the Range of  
the Following Percentages  
of Retail Charges

Then the Hospital  
Would Pay the Physician the  
Following Percentage of the  
Amount within Each Such Range

75-85%

10%

85-95%

15%

95% and greater

20%

Hollywood Community Hosp., Program Statement 1 (copy on file with U. MICH. J.L. REF.).

34. *Id.*

35. *Id.*

36. Richman, *supra* note 26, at 48. This investigation was initiated at the request of the American Medical Association (AMA) and is examining the effects of the plan, including impacts on quality of care. Telephone interview with Donald Goldman, attorney for Hollywood Community Hospital (Feb. 10, 1986) [hereinafter Goldman interview]. For a discussion of the AMA's primary objections to the incentive plan, see *infra* text accompanying notes 93-98.

37. Richman, *supra* note 26, at 53. The Hollywood Community Hospital expects "a clean bill of health" from the Regional Inspector General regarding the impact on quality of care. Goldman interview, *supra* note 36.

38. The terminology used, be it "profit sharing," "risk sharing," or "kickback," see *infra* Part II, is of little consequence, so this Note uses the term with the least objectionable connotation.

39. "The AMA evidently sees [risk-sharing arrangements] as a form of fee splitting, in which the hospital makes some money from its physicians' behavior. . . . In fact, many



Association (AMA) has long regarded the practice of fee splitting as improper:<sup>40</sup> "[P]hysicians are not entitled to derive a profit that results directly or indirectly from services delivered by other health care providers who are not their employees or agents."<sup>41</sup>

Another reason health care providers did not implement profit-sharing programs more quickly was lack of necessity and incentive in the former system of cost-based reimbursement.<sup>42</sup> Under cost-based reimbursement, hospitals had little incentive to control the amount of care administered because the reimbursement received covered the full reasonable amount of care provided.<sup>43</sup> The same was and remains true of physician reimbursement. Medicare reimburses physicians according to usual, reasonable, and customary fees.<sup>44</sup> Thus, the more care provided, the greater the physician's gross income. There is no incentive in the PPS itself to control physician costs because the PPS does not affect physician reimbursement.<sup>45</sup>

Although incentive plans may encourage cost-effective behavior in physicians, these plans and similar forms of profit sharing face a formidable obstacle: the language of the fraud and abuse provisions<sup>46</sup> of the Medicare statute.

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states have incorporated statutory opposition to fee splitting into their medical practice acts." Friedman, *The Lure of Risk-Sharing Arrangements*, HOSP. MED. STAFF, Jan. 1985, at 27 (interview with William F. Jessee, M.D.).

40. *Id.*

41. Judicial Council, AMA, 38th Interim Meeting, Report D—Ethical Implications of Hospital-Physician Risk-Sharing Arrangements Under DRGs (Dec. 2-5, 1984) [hereinafter Judicial Council, Report D] (copy on file with U. MICH. J.L. REF.), reprinted in 253 J. A.M.A. 2425 (1985).

42. H.R. REP. NO. 404, *supra* note 15, at 26; see 1 PPS Hearing, *supra* note 4, at 16 (statement of Richard S. Schweiker, Secretary of Health and Human Servs.); Goldsmith, *Entrepreneurship: Its Place in Health Care*, HOSP. F., Mar.-Apr. 1984, at 17 (suggesting that adaptation to the new competitive era in health care provision necessitates the adoption of entrepreneurial values); Lowenstein, Iezzoni & Moskowitz, *Prospective Payment for Physician Services: Impact on Medical Consultation Practices*, 254 J. A.M.A. 2632, 2633 (1985) (describing possible effects of proposed physician DRGs on consultation practices).

43. See *supra* text accompanying note 10.

44. See *supra* note 28 and accompanying text.

45. Jessee & Suver, *supra* note 26, at 3.

46. 42 U.S.C. § 1395nn (1982 & Supp. III 1985); see *infra* note 47.

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## II. THE PLAIN LANGUAGE OF THE FRAUD AND ABUSE PROVISIONS

The plain language of the fraud and abuse provisions<sup>47</sup> is consistent with the premise that hospitals and physicians, in offering and accepting, respectively, the financial rewards of hospital-physician incentive plans, violate the Social Security Act. Under the plans, hospitals knowingly and willfully<sup>48</sup> pay a monetary remuneration<sup>49</sup> to physicians. Through such payments, the hospitals induce physicians to refer certain Medicare patients to these hospitals and to order or arrange for goods and services for those patients in a particular fashion.<sup>50</sup>

Thus, hospital-physician incentive plans can violate the provisions of the fraud and abuse statute dealing with illegal remuneration in several ways. First, physicians violate the provisions when they knowingly and willfully receive remuneration in return for referring patients to the offering hospital<sup>51</sup> for the cost-effective ordering of goods or services paid for by Medicare.<sup>52</sup> The hospital violates the provisions by offering or paying a re-

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47. *Id.* The provisions governing the legality of incentive plans are as follows:

(b) Illegal remunerations

(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this subchapter, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this subchapter,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this subchapter, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this subchapter,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.

*Id.* § 1395nn(b)(1)-(2) (1982).

48. *See infra* notes 76-81 and accompanying text.

49. *See infra* notes 55-68 and accompanying text.

50. *See infra* notes 69-75 and accompanying text.

51. 42 U.S.C. § 1395nn(b)(1)(A) (1982).

52. *Id.* § 1395nn(b)(1)(B).

muneration to induce physicians to refer patients to the hospital for services paid for by Medicare.<sup>53</sup> Finally, the hospital violates the statute by offering or paying a remuneration to induce physicians to order or arrange for goods or services paid for by Medicare.<sup>54</sup> Thus, "remuneration," "referral," and "knowing and willful" are key terms in establishing fraud and abuse.

### A. Remuneration

Congress added the term "any remuneration" in 1977 in order to clarify the former language.<sup>55</sup> Originally, the statute simply proscribed kickbacks, bribes, and rebates.<sup>56</sup> Courts encountered numerous cases exemplifying definitional problems with the original language.<sup>57</sup> The addition of the words "any remunera-

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53. *Id.* § 1395nn(b)(2)(A).

54. *Id.* § 1395nn(b)(2)(B). This Note will not discuss this aspect of the statutory violation in depth. The plans themselves are intended and designed specifically to have the prohibited effect. Physicians accept rewards in return for the encouraged behavior. The violations are obvious. See, e.g., the discussion of Hollywood Community Hospital's Savings Program, *supra* notes 32-35 and accompanying text.

55. Medicare-Medicaid Anti-Fraud and Abuse Amendments, Pub. L. No. 95-142, sec. 4, 91 Stat. 1175, 1179, 1180 (1977) (codified as amended at 42 U.S.C. § 1395nn(b)(1)-(2) (1982)); see SUBCOMM. ON HEALTH OF THE HOUSE COMM. ON WAYS AND MEANS, 95TH CONG., 1ST SESS., H.R. 3: MEDICARE-MEDICAID ANTI-FRAUD AND ABUSE AMENDMENTS 8-10 (Comm. Print 1977).

56. 42 U.S.C. § 1395nn(b) (1976) (amended 1977).

57. One such case is *United States v. Porter*, 591 F.2d 1048 (5th Cir. 1979). *Porter* involved a laboratory operator convicted, under the original language, of offering kickbacks or bribes to physicians in exchange for referrals. The defendant had paid "handling fees" of \$35 to induce physicians to refer patients to his laboratory. These fees were allegedly paid for interpretation of results, for which Medicare paid less than six dollars per patient. *Id.* at 1051. The defendant appealed, claiming his actions did not come within the statutory terms "kickback" and "bribe."

In reversing the conviction, the Fifth Circuit stated that, absent a statutory definition of relevant terms, they are assumed to be used as they are commonly and ordinarily understood. The court understood "bribe" to encompass "acts that are *malum in se* because they entail either a breach of trust or duty or the corrupt selling of what our society deems not to be legitimately for sale." *Id.* at 1053 (quoting *United States v. Zacher*, 586 F.2d 912, 916 (2d Cir. 1978)). The court defined "kickback" as a "secret return to an earlier possessor of part of a sum received." *Id.* at 1054 (emphasis in original). Perhaps this narrow definition of kickback was what Congress attempted to correct when it clarified the statutory language.

The majority of cases after *Porter* reject its narrow definitions. See, e.g., *United States v. Hancock*, 604 F.2d 999, 1002 (7th Cir.) ("We cannot agree that the term kickback is limited to a return of funds to an earlier possessor. The term is commonly used and understood to include 'a percentage payment . . . for granting assistance by one in a position to open up or control a source of income.'") (quoting Webster's Dictionary), *cert. denied*, 444 U.S. 991 (1979); see also *United States v. Weingarden*, 468 F. Supp. 410, 412 (E.D. Mich. 1979), *aff'd*, 625 F.2d 111 (6th Cir.), *cert. denied*, 449 U.S. 1034 (1980).

In *United States v. Zacher*, 586 F.2d 912 (2d Cir. 1978), the court reversed the conviction of a nursing home operator convicted of receiving bribes from families of Medicaid

tion" in 1977, however, significantly broadened the scope of the fraud and abuse provisions. Because Congress did not define the term "remuneration," the word must be interpreted in light of its common and ordinary meaning.<sup>58</sup>

"Remuneration" is generally defined as a reward or compensation,<sup>59</sup> or as a payment for services.<sup>60</sup> Under this definition, incentive plans plainly come within the language of the Fraud and Abuse Amendments. Through such incentive plans, hospitals give physicians a bonus in addition to Medicare's payment for the physicians' services rendered.<sup>61</sup>

In the legislative history of the Fraud and Abuse Amendments of 1977, Congress announced no intent to deter new activities by the addition of "remuneration" but instead discussed the same types of abuses that led to the original enactment of the fraud and abuse statute.<sup>62</sup> Although this may suggest that Congress did not intend to prohibit practices such as profit sharing, Congress must have understood the significant ramifications of the

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patients. *Id.* at 913. Section 1909 of the Medicaid Act, 42 U.S.C. § 1396h (1982), contains a provision identical to the Medicare fraud and abuse statute. In deciding the case, the Second Circuit considered the proper meaning and connotation of "kickback" and "bribe." The court concluded that the terms kickback, rebate, and bribe connote "a corrupt payment or receipt of payment in violation of the duty imposed by Congress on providers of services to use federal funds only for intended purposes and only in the approved manner." 586 F.2d at 916. For a discussion of these and other cases decided before the addition to the statute of the words "any remuneration," see Comment, *Physician Fraud in the Medicare-Medicaid Programs—Kickbacks, Bribes, and Remunerations*, 10 MEM. ST. U.L. REV. 684 (1980).

58. See *Porter*, 591 F.2d at 1053. The "Plain Meaning Rule" of statutory construction requires that courts first examine the language of a statute. If the meaning of the statute is plain, "the sole function of the courts is to enforce it according to its terms." 2A N. SINGER, SUTHERLAND STATUTES AND STATUTORY CONSTRUCTION § 46.01, at 73 (Sands 4th ed. 1984) (citing *Caminetti v. United States*, 242 U.S. 470 (1917)).

59. BLACK'S LAW DICTIONARY 1165 (5th ed. 1979).

60. WEBSTER'S NEW COLLEGIATE DICTIONARY 971 (1979).

61. See *supra* notes 29-33 and accompanying text.

62. Among the most prevalent types of fraud Congress sought to discourage was the "Medicaid mill." The Medicaid mill is typically an inner-city facility deriving most of its business from Medicare and Medicaid patients. The most common types of mill violations include medically unfounded referrals within the mill, billing for multiple services to family members who did not seek treatment, billing for services more extensive than those actually provided, directing a patient to a particular pharmacy, and billing for services not rendered. H.R. REP. NO. 393, 95th Cong., 1st Sess., pt. 2, at 45, *reprinted in* 1977 U.S. CODE CONG. & AD. NEWS 3039, 3047-48. Also discussed in the legislative history were violations by clinical laboratories, independent practitioners, and nursing homes. *Id.* at 46-47, *reprinted in* 1977 U.S. CODE CONG. & AD. NEWS at 3048-50; see 1 *Medicare and Medicaid Frauds: Joint Hearing Before the Subcomm. on Long-Term Care and the Subcomm. on Health of the Elderly of the Senate Special Comm. on Aging*, 94th Cong., 1st Sess. 40 (1975) [hereinafter 1 *Medicare and Medicaid Frauds Hearing*] (statement of

addition of the words "any remuneration."<sup>63</sup> The use of such a broad term suggests that Congress intended to expand the coverage of the statute, perhaps to cover more than the most blatant forms of Medicare fraud and abuse. Congress did not distinguish between "good" remuneration and "bad" remuneration.<sup>64</sup> Rather, it declared "any remuneration" a violation of the statute.<sup>65</sup>

The Third Circuit's recent interpretation of the fraud and abuse provisions in *United States v. Greber*<sup>66</sup> supports this con-

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Paul M. Allen, Chief Deputy Director, Michigan Dep't of Social Servs., regarding Medicaid fraud).

The most costly, noncriminal abuse identified in the Medicare system was the furnishing of excessive services. H.R. REP. NO. 393, *supra*, at 47, reprinted in 1977 U.S. CODE CONG. & AD. NEWS at 3050. For further discussion, see generally 1 *Medicare and Medicaid Frauds Hearing, supra*; 2 *Medicare and Medicaid Frauds: Hearing Before the Subcomm. on Long-Term Care of the Senate Special Comm. on Aging*, 94th Cong., 2d Sess. (1975); H.R. REP. NO. 393, *supra*, reprinted in 1977 U.S. CODE CONG. & AD. NEWS 3039. See also Tepper, *Medicare and Medicaid Fraud*, 18 AM. CRIM. L. REV. 286, 288-89 (1980).

63. "It is an elementary rule of statutory construction that effect must be given, if possible, to every word, clause and sentence of a statute." 2A N. SINGER, *supra* note 58, § 46.06, at 104 (quoting *State v. Bartley*, 39 Neb. 353, 58 N.W. 172 (1894)).

64. See *supra* note 62.

65. This assertion becomes less plausible, however, when one examines the implications of such a literal reading of the statute. For example, under a strict literal interpretation, a hospital could be found in violation of the Amendments for simply receiving Medicare funds. The hospital would be knowingly and willfully soliciting remuneration directly and overtly in cash in return for ordering or arranging for a service for which payment may be made by Medicare. This result is surely absurd, but follows from a strict literal reading. A similar reading of that part of the statute that prohibits the offering or paying of remuneration to induce referrals, 42 U.S.C. § 1395nn(b)(2) (1982), see *supra* note 47, would create doubt as to the legality of the government's reimbursement of hospitals and physicians as this type of remuneration induces such parties to order or arrange for the ordering of services for Medicare patients.

These examples seem to indicate that Congress, when using the words any remuneration, did not mean to imply that, regardless of the form or intent, if money changes hands the transaction is illegal. Congress clearly intended, however, to include all but the absurd readings. Under § 1395nn(b)(3)(B), "any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services" is excluded from the coverage of the provisions dealing with illegal remunerations. Congress' specific exclusion of employer-employee relationships from the statute's coverage suggests that any other such payment relationship, including hospital-physician incentive plans, falls within its prohibitions on remuneration. For an interpretation of the word "remuneration" written prior to *United States v. Greber*, 760 F.2d 68 (3d Cir.), cert. denied, 106 S. Ct. 396 (1985), discussed *infra* notes 66-68 and accompanying text, see Comment, *supra* note 57, at 693-95.

66. 760 F.2d 68 (3d Cir.), cert. denied, 106 S. Ct. 396 (1985). The facts of *Greber* are typical of Medicare fraud cases involving referrals in that the defendant was one of the bad actors that the statute was enacted to cover. See, e.g., *United States v. Duz-Mor Diagnostic Laboratory*, 650 F.2d 223 (9th Cir. 1981); *United States v. Hancock*, 604 F.2d 999 (7th Cir.), cert. denied, 444 U.S. 991 (1979); *United States v. Porter*, 591 F.2d 1048 (5th Cir. 1979); *United States v. Weingarden*, 468 F. Supp. 410 (E.D. Mich. 1979), *aff'd*

clusion. To date, this is the only case to shed light on the meaning of "any remuneration." *Greber* involved "kickbacks" to referring physicians of forty percent of the Medicare receipts on the referring physicians' patients. A jury convicted Greber, an osteopathic physician, of violating the Medicare fraud statute.<sup>67</sup> On appeal, the Third Circuit defined "any remuneration" to include "not only sums for which no actual service was performed but also those amounts for which some professional time was expended."<sup>68</sup> Here, the court broadly interpreted "any remuneration" in its determination of whether payments are illegal.

Under the *Greber* court's interpretation of the statutory language, the transfer of Medicare funds from one physician to another is illegal. Defendants cannot attempt to insulate themselves from criminal liability by claiming that the transfer of funds constituted payment for services rendered. In applying this line of reasoning to the relationship between a hospital and physician created by incentive plans, clearly the hospital pays the nonemployee physicians for professional services—the cost-effective use of hospital resources in patient care. Nevertheless, this relationship does not shield the participants in an incentive plan from liability.

### B. Referrals

The Medicare fraud statute also requires that the remuneration be offered to induce a person to refer, and be received for referring, Medicare patients to a particular provider. Incentive plans satisfy this requirement by inducing physicians to refer Medicare patients to the hospital offering the incentive.<sup>69</sup> Consider the following hypothetical: Doctor A practices in a city of moderate size with several hospitals, two of which, Hospitals X and Y, have granted the doctor admitting and staff privileges.<sup>70</sup> Doctor A is a thoracic surgeon and has a booming practice in these days of high anxiety. Hospital X recently implemented an incentive plan in order to combat the adverse financial effects of

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*sub nom.* United States v. Tapert, 625 F.2d 111 (6th Cir.), *cert. denied*, 449 U.S. 1034 (1980).

67. 760 F.2d at 69.

68. *Id.* at 71.

69. 42 U.S.C. § 1395nn(b)(1)(A), (2)(A); *see supra* note 47.

70. Staff physicians are in a slightly different position than are physicians who function as independent contractors with the hospital. Staff physicians will not have an opportunity to prefer a particular hospital because of their employment situation, but the other concerns, discussed *infra*, will apply to both types of physicians.

Medicare's DRG reimbursement system. Hospital Y considers such plans of questionable legality and decides against implementation.

When Doctor A seeks to admit a patient to a hospital, she will decide whether to have the patient admitted to Hospital X or Hospital Y. Assuming that the two hospitals have identical services and equipment, her decision may depend on the nature and severity of the patient's illness. If the patient's diagnosis corresponds to a generous DRG and the length-of-stay is not likely to be extreme, the incentive plan encourages the doctor to send the patient to Hospital X, which will probably turn a profit on the patient and distribute part of the proceeds to the doctor. If the patient's condition is less favorable and the DRG reimbursement low in relation to treatment cost, Doctor A will not care where the patient is sent because it will not affect her income at either location.<sup>71</sup> Because the incentive plans only become effective if a doctor's discharges result in profits for the hospital,<sup>72</sup> a patient who incurs costs in excess of the DRG reimbursement will not trigger the incentive plan.<sup>73</sup>

Such behavior by physicians may create a windfall for Hospital X, which provided an incentive for its physicians to admit their less seriously ill patients. At the same time, other hospitals in the area, like Hospital Y, will be burdened by a larger proportion of more seriously ill patients with longer lengths-of-stay. These other hospitals might respond by setting up their own incentive plans. If all hospitals set up incentive plans, however, the variations among the plans utilized would still induce physicians to refer patients to particular institutions. As each plan is likely to attract different physicians, the industrywide implementation of such plans will not discourage financially motivated referrals. Moreover, the likelihood of all hospitals implementing such plans is slight. Because many hospitals are facing bankruptcy,<sup>74</sup> few will be able to implement a plan that will re-

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71. This assumes the incentive plan does not provide sanctions for overutilization. One type of incentive plan, described by the AHA, would induce Doctor A to send her sicker patients to Hospital Y. Under this type of plan, the hospital pays a flat monthly fee to those physicians who on the whole have reduced their patients' length-of-stay by one day. Under this scheme, physicians would jeopardize their chances of receiving incentive payments if they admitted patients who might stay in the hospital in excess of a "normal" length-of-stay in relation to their diagnosis. Select Legal Advisory Comm. on Medicare, Office of Legal & Regulatory Affairs, AHA, Medicare-Medicaid Antifraud and Abuse Amendments: Application to Hospital Activities Under the Medicare Prospective Payment System 10 (Feb. 1985) (copy on file with U. MICH. J.L. REF.).

72. See *supra* notes 31 & 33 and accompanying text.

73. *Id.*

74. Cf. *supra* note 23 and accompanying text.

duce the margin of profit, leaving the hospital with little to use in simply maintaining solvency.

The potential effects of incentive plans on admissions directly conflict with the language of the Fraud and Abuse Amendments to the Medicare Act. The statute proscribes remuneration intended to induce referrals. In the example considered above, if Doctor A sends her profitable patients to Hospital X because of the incentive plan, the hospital has induced that referral.

The primary obstacle to finding a violation of this provision, then, is proof that the inducement is intentional.<sup>75</sup> Thus, fact patterns and circumstances are likely to be determinative in evaluating any particular plan. Nevertheless, the fact that incentive plans induce selective referrals will be readily apparent in any situation in which a physician has a choice of where to admit a particular patient.

### C. *"Knowingly and Willfully"*

The fraud and abuse provisions further require that remuneration be knowing and willful in order to constitute a crime. Thus the statute is aimed at those who intentionally violate the prohibitions of the Amendments.<sup>76</sup>

75. 42 U.S.C. § 1395nn(b)(1)-(2) (1985); see *supra* note 47.

76. Knowingly and willfully is most commonly used in a criminal context and is variously defined. See *United States v. McKim*, 26 F. Cas. 1122, 1122 (W.D. Pa. 1869) (No. 15,693) (The court held that under an act that required the violation be knowing and willful, intent to defraud is not necessary. "The penalty is incurred, the offense complete, when the defendants 'have left undone those things which they ought to have done' ('and done things which they ought not to have done'), and this without any fraudulent or criminal intent."); *United States v. Kirby*, 74 U.S. 482 (1868). In *Kirby*, the Court stated that knowingly and willfully applies

to those who know that the acts performed will have that effect, and perform them with the intention that such shall be their operation. When the acts which create [the statutory violation] are in themselves unlawful, the intention [to violate the statute] will be imputed . . . although the attainment of other ends may have been his primary object.

*Id.* at 485-86. In *United States v. Fifty Waltham Watch Movements*, 139 F. 291 (N.D.N.Y. 1905), the court stated:

'Knowingly' is frequently used . . . in contradistinction to 'innocently,' 'ignorantly,' or 'unintentionally.' . . .

. . . .  
 . . . Conceding that to constitute a criminal offense in violating a statute there must be 'a criminal intent,' or a 'bad mind,' it seems clear to this court that, where the statute offended against fails to specify a particular intent as the one which must exist in order to make the doing of the act criminal, the knowing and willful violation of the statute (if not justified) for some personal end or gain shows the bad mind and establishes the criminal intent.



Hospitals clearly can foresee, and may deliberately encourage, the potential inducement of referrals when setting up incentive plans. That incentive plans encourage physicians to admit patients selectively must be obvious to hospital administrators.<sup>77</sup> Clearly, administrators who desire this effect violate the statute. But even if not deliberate, when administrators, with knowledge that the incentive plan would induce referrals, implement it anyway, they violate the statute.

*United States v. Greber*<sup>78</sup> facilitates a more definite showing of purpose. In *Greber*, the Third Circuit held that "if one purpose of the payment was to induce future referrals, the medicare statute has been violated."<sup>79</sup> Hospital-physician incentive plans induce physicians to refer profitable patients to the offering hospital and to order services in a particular manner. The plans reward physicians for admitting profitable patients. Commentators note that the PPS will encourage hospitals to attempt to admit only the less costly patients.<sup>80</sup> An incentive plan should suggest the possibility of an attempt by the hospital in question to alter its case mix by encouraging its physicians to admit certain types of patients. Nevertheless, even if a purpose to induce referrals could not be proven, a purpose to induce physicians to order or arrange for particular services or goods is evident on the face of the plans. The basic philosophy behind such plans is that physicians will administer cost-effective care if paid to do so.

*Id.* at 300 (citing *United States v. Claypool*, 14 F. 127 (W.D. Mo. 1882)); see also W. LAFAVE & A. SCOTT, *HANDBOOK ON CRIMINAL LAW* § 28, at 196 (1972) (footnotes omitted):

[For] crimes which require that the defendant intentionally cause a specific result . . . it is now generally accepted that a person who acts . . . intends a result of his act . . . under two quite different circumstances: (1) when he consciously desires that result . . . ; and (2) when he knows that that result is practically certain to follow from his conduct, whatever his desire may be as to that result.

But see *Elfbrandt v. Russell*, 97 Ariz. 140, 145-46, 397 P.2d 944, 947 (1964) ("evil motive" necessary or act committed voluntarily and purposefully), *rev'd on other grounds*, 384 U.S. 11 (1966); *State ex rel. Grover v. Grover*, 158 Or. 635, 639-40, 77 P.2d 430, 432 (1938) ("determination with a bad intent" needed) (citing *Felton v. United States*, 96 U.S. 699, 702 (1877)).

77. See *supra* notes 70-73 and accompanying text.

78. 760 F.2d 68 (3d Cir.), *cert. denied*, 106 S. Ct. 396 (1985). For a discussion of *Greber*, see *supra* notes 66-68 and accompanying text.

79. *Id.* at 69 (emphasis added).

80. Sorkin suggests that the PPS should serve as a disincentive for hospitals to increase patient volume because no additional profits would result from the additional patients admitted. However, if the hospital could alter its case mix, that is, if it could get a disproportionate number of profitable patients, the hospital would beat the PPS and increased profits would result. A. SORKIN, *supra* note 14, at 45-47; Comment, *Provider Liability Under Public Law 98-21: The Medicare Prospective Payment System in Light of Wickline v. State*, 34 BUFF. L. REV. 1011, 1018-19 (1985).

The rewards are intended to influence the behavior of physicians in caring for patients.<sup>81</sup>

### III. ABUSES AND THREATS TO QUALITY HEALTH CARE

Hospital administrators' implementation of incentive plans is designed to ensure the economic well-being of the hospital.<sup>82</sup> Ideally, under such a plan, each patient would receive only the care necessary to treat his or her diagnosed condition. Increased efficiency in the health care industry would reduce waste in the Medicare program. In other words, the purpose of the incentive plans is increased efficiency within the system, an indisputably admirable goal in light of the escalating financial difficulties the Medicare system faces.<sup>83</sup> Thus, because the primary purpose of the DRG system is to decrease health care costs,<sup>84</sup> one might argue that incentive plans further the will of Congress rather than frustrate it.

Congress' primary concern when enacting the Fraud and Abuse Amendments, as evidenced in the legislative histories, was that money not necessary for patient care not be taken out of the Medicare and Medicaid systems.<sup>85</sup> Incentive plans do not appear to frustrate this concern. On their face, incentive plans have no effect whatsoever on amounts of Medicare funds paid to hospitals.<sup>86</sup> Regardless of the implementation of incentive plans, hospitals receive only those funds authorized under a particular DRG. This fact, together with the efficiency arguments,<sup>87</sup> sug-

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81. See *supra* notes 29-31 and accompanying text and text accompanying notes 34-35.

82. See *supra* notes 29-35 and accompanying text.

83. See *supra* notes 15-16 and accompanying text.

84. See *supra* note 13 and accompanying text.

85. See *infra* note 92.

86. Note, *supra* note 31, at 766, suggests that without "deception" or "waste" in hospital-physician incentive plans, no violation of the fraud and abuse provisions exists. This suggestion, however, is simply incorrect. As to "deception," the statute applies whether the action is overt or covert. 42 U.S.C. § 1395nn(b)(1)-(2) (1982). And, as to "waste," increased cost to the Medicare program is not an essential element of a fraud and abuse violation. See *United States v. Ruttenberg*, 625 F.2d 173, 177 (7th Cir. 1980). In *Legal Aspects of Health Care Reimbursement*, the authors suggest that kickbacks may be permissible if the cost to Medicare is not increased, R. BUCHANAN & J. MINOR, *supra* note 17, at 133. The clear statutory language of the fraud and abuse statute, however, does not support their contention. Furthermore, although the actual payment to the physician does not increase the costs to the Medicare program, manipulation of the system by physicians, which the plans themselves encourage, will result in a substantial drain on Medicare.

87. See *supra* notes 82-84 and accompanying text.

gests the attractiveness of incentive plans as a means of fulfilling the PPS goal of cost containment.

The potential for fraud and abuse in implementation of the incentive plans, however, outweighs the possible cost-effectiveness of the plans. Regardless of whether the plans are, in theory, cost-effective, they promote fraudulent and abusive practices that defeat cost containment. Among the fraudulent or abusive practices these plans promote is "DRG creep," whereby doctors assign more "profitable" DRGs to "unprofitable" patients. Incentive plans also encourage the deliberate early discharge and readmission of the same patient. Through this practice, the hospital receives additional Medicare reimbursement as a result of two DRGs being assigned: one DRG on the initial admission and a second on the readmission. More tragically, incentive plans will produce an adverse impact on quality of care.

#### A. *Fraudulent and Abusive Practices*

In enacting the Fraud and Abuse Amendments, Congress sought to limit the use of Medicare funds to their intended purpose—providing a safety net of necessary medical care for the elderly.<sup>88</sup> The primary purpose of the amendments was "to strengthen the ability of the Federal and State governments to find and correct abuse and to detect and prosecute fraud."<sup>89</sup> Fraud, according to the legislative history, is a purposeful attempt to receive an unauthorized benefit through an intentional deception or misrepresentation.<sup>90</sup> Program abuse is less clearly defined but includes activities "inconsistent with accepted sound medical or business practices resulting in excessive and unreasonable financial cost to either medicare or medicaid."<sup>91</sup> Con-

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88. 1 *Medicare and Medicaid Frauds Hearing*, *supra* note 62, at 7 (statement of Sen. Church).

89. H.R. REP. NO. 393, *supra* note 62, at 48, reprinted in 1977 U.S. CODE CONG. & AD. NEWS at 3050.

90. *Id.*

91. *Id.*; see also *Medicare-Medicaid Anti-Fraud Act: Hearing on H.R. 15536, H.R. 13347, H.R. 14805, H.R. 6483, and H.R. 6623 Before the Subcomm. on Health and the Environment of the House Comm. on Interstate and Foreign Commerce*, 94th Cong., 2d Sess. 81-82 (1976) (statement of Beverlee A. Myers, Lecturer, Department of Medical Care Org., School of Pub. Health, University of Mich.) (quoting STAFF OF THE SUBCOMM. ON HEALTH AND THE ENVIRONMENT OF THE HOUSE COMM. ON INTERSTATE AND FOREIGN COMMERCE, 94TH CONG., 2D SESS., A DISCURSIVE DICTIONARY OF HEALTH CARE 5 (Comm. Print 1976)):

[A]buse is defined as "improper or excessive use of program benefits, resources or services by either providers or consumers. Abuse can occur intentionally or

gress designed the amendments to cover those persons who defraud or abuse the Medicare and Medicaid programs for personal gain.<sup>92</sup>

The AMA's opposition to incentive plans<sup>93</sup> poses a substantial challenge to any argument that the plans do not constitute abuse because they comport with "accepted sound medical . . . practices." The AMA believed that the plan it evaluated gave doctors an incentive to admit those patients more appropriately treated at a less costly facility or as outpatients.<sup>94</sup>

The AMA espoused three reasons for opposing the particular incentive plan. First, the plan subverted the Medicare system by undercutting the premise that a random sample of patients will be admitted to each acute care hospital.<sup>95</sup> If greater numbers of patients with "profitable" DRGs are admitted to hospitals with incentive plans, other area hospitals are likely to receive those patients with "unprofitable" DRGs. Thus, the other area hospitals will not have the same "break even" potential as hospitals with incentive plans. Second, the AMA feared the plan would increase the number of patients transferred out of hospitals with incentive plans to other area hospitals.<sup>96</sup> Third, such plans would undercut peer review organizations' (PROs)<sup>97</sup> monitoring

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unintentionally, when services are used which are excessive or unnecessary; which are not the appropriate treatment for the patient's condition . . . . It should be distinguished from fraud, in which deliberate deceit is used by providers or consumers . . . . Abuse is not necessarily either intentional or illegal."

92. "When Congress passed the Medicare/Medicaid Anti-Fraud and Abuse Amendments of 1977; it was our hope that we wouldn't have to keep hearing about millions of lost Federal dollars. . . . [I]t is evident that millions, and perhaps billions, of dollars are still being wasted in our medicare and medicaid programs." *Medicare & Medicaid Fraud: Hearing Before the Subcomm. on Health and Long-Term Care of the House Select Comm. on Aging*, 96th Cong., 2d Sess. 3 (1980) (statement of Rep. Abdnor); *1 Medicare and Medicaid Frauds Hearing*, *supra* note 62, at 4 (statement of Sen. Percy).

93. The AMA expressed its opposition to incentive plans in a letter to the Department of Health and Human Services regarding the Hollywood Community Hospital plan, *see* Richman, *supra* note 26, and in one of its Judicial Council Reports, Judicial Council, Report D, *supra* note 41. It stated that "the physician is not entitled to derive a profit which results from services provided by the hospital under DRG payments." *Id.* at 176, *reprinted in* 253 J. A.M.A. at 2425.

94. Richman, *supra* note 26, at 48.

95. *Id.* at 48, 53.

96. *Id.* This apparently assumes that the incentive plan penalizes in some manner for overutilization of services. The Hollywood Community Hospital plan, however, *see supra* note 33, does not, from their program statement, appear to do so.

97. PROs are groups of local physicians, 42 U.S.C. § 1320c-1(1)(A) (1982), who review medical decisionmaking to determine whether care is reasonable and necessary, whether services meet professional standards of quality, and that care cannot be provided more appropriately and economically on an outpatient basis or in a different type of health care facility. *Id.* § 1320c-3(a)(1)(A)-(C). If the Secretary of Health and Human Services determines (through information that PROs supply) that patients are being admitted

of physician practices because PROs rely on accurate records as a check on hospital practice. Under the incentive plan, doctors have an "incentive to rig the DRG system."<sup>98</sup>

Incentive plans are likely to magnify existing abuses such as "DRG creep." DRG creep refers to physicians' assigning a patient to a DRG with a higher reimbursement rate than that to which the patient should properly be assigned.<sup>99</sup> Waving the carrot of profit sharing under the noses of unethical or marginally ethical physicians, who put personal financial gain before their patients' welfare, would encourage an increase in DRG creep and discourage systemwide cost containment because the larger the reimbursement for the hospital, the greater the possibility that the doctor will make money.<sup>100</sup>

By encouraging DRG creep, the incentive plans frustrate legislative purpose. Hospitals improperly obtain more Medicare funds than that which the HCFA deems proper for care of a particular illness.<sup>101</sup> This countervailing consideration outweighs the

unnecessarily or are being discharged and readmitted unnecessarily, the Secretary may assess penalties, including denying payment and requiring the hospital to correct or prevent the practice. *Id.* § 1395ww(f)(2) (Supp. III 1985).

98. Richman, *supra* note 26, at 53. Here, the AMA is apparently concerned that incentive plans will encourage the practice of "DRG creep." See *infra* text accompanying notes 99-101.

99. See, e.g., J. Griffith, in DRG's—What's Next? Two Views, *supra* note 26, at 18; Stern & Epstein, *Institutional Responses to Prospective Payment Based on Diagnosis Related Groups: Implications for Cost, Quality, and Access*, 312 NEW ENG. J. MED. 621 (1985); Schnitzer, *Physicians and Prospective Payment*, 6 WHITTIER L. REV. 863 (1984) (speech presented to the Third Annual Whittier Health Law Symposium, Mar. 24, 1984, discussing ways to beat the DRG system). Schnitzer raises the question with which this Note deals but does not address it specifically. *Id.* at 868.

100. Lowenstein, Iezzoni & Moskowitz, *supra* note 42, describes the incentives inherent in the PPS itself that limit its cost-containment potential:

Hospitals are encouraged to (1) admit larger numbers of patients, especially patients with easy-to-care-for illnesses and short anticipated lengths of stay; (2) split therapy for an illness into two parts, to spread a patient's care over two hospital admissions; (3) unbundle diagnostic procedures, shifting some to the ambulatory setting (outside the PPS); (4) upgrade principal and secondary diagnostic codes, to obtain a higher-paying DRG assignment ("DRG creep"); and (5) perform more complex surgical procedures to inflate the DRG ("procedure inflation").

*Id.* at 2633. The authors question the effects of proposed physician DRGs on existing incentives. Physician DRGs, like incentive plans, may further encourage physicians and hospitals to avoid cost containment by the above described means. See also Wennberg, McPherson & Caper, *Will Payment Based on Diagnosis-Related Groups Control Hospital Costs?*, 311 NEW ENG. J. MED. 295, 299 (1984).

101. PROs, see *supra* note 97, may serve to discourage both inappropriate discharge and readmittances and DRG creep. Because a sufficient review of the necessity and efficiency of length-of-stay and services performed may be accomplished "on a sample or other basis" of admissions, 42 U.S.C. § 1395x(k) (1982), however, PROs may not be very effective in curbing abuses. According to a recent study by the Office of Analysis and

efficiency argument in favor of incentive plans. Although hospitals using incentive plans may increase revenues or simply maintain solvency, the Medicare system suffers as the hospital drains from the system additional funds not necessary to patient care.

Incentive plans may also encourage some physicians to discharge patients before it is medically appropriate and then to readmit them in order to provide further care. Through this practice, a patient who would ordinarily create a loss for the hospital because of an unusually long length-of-stay or an unusually complicated illness will provide income for the hospital under two DRGs: that assigned at the first admission, and that assigned at the second.<sup>102</sup>

### B. *An Intolerable Threat to Health Care*

Although the Medicare statute has been amended to encourage cost containment, Congress did not intend to make economic efficiency the sole criterion by which to assess hospital policies and procedures. The adverse impact on quality of care that incentive plans promote greatly outweighs any benefit to the hospital and the Medicare system that such plans may provide.<sup>103</sup> The quality of patient care remains a central concern,<sup>104</sup>

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Inspections of the Office of Inspector General, "It appears that many PROs have not effectively used the authorities or the processes available to address instances of poor quality care associated with premature discharges . . . ." Office of Analysis and Inspections, Office of Inspector Gen., Region V, Inspection of Inappropriate Discharges and Transfers, reprinted in *Out "Sooner and Sicker": Myth or Medicare Crisis?: Hearing Before the House Select Comm. on Aging*, 99th Cong., 2d Sess. 10, 12 (1986) [hereinafter *Medicare Crisis Hearing*].

102. See Lowenstein, Iezzoni & Moskowitz, *supra* note 42; Schnitzer, *supra* note 99, at 864. But see *Do DRGs Diminish the Quality of Care?*, *supra* note 23, at 431 (asserting that DRGs are not the cause of premature discharge).

103. See *supra* notes 82-84 and accompanying text.

104. A congressional focus on quality of care provided to Medicare patients was apparent in recent legislative hearings on quality of care under DRGs. See, e.g., *Joint Hearing on Quality Health Care*, *supra* note 13. Concerns regarding quality of care were also raised in congressional hearings on prospective payment. See, e.g., 1 *PPS Hearing*, *supra* note 4, at 47 (statement of Sen. Durenberger); see also Matsui, *supra* note 13; cf. *Do DRGs Diminish the Quality of Care?*, *supra* note 23, at 432 (stating that although the federal government expresses concern with quality of care under the PPS, it has made no effort to study the actual impact).

At least one court has shown concern with quality of care: "The payments to [the defendant] did not increase the cost to the government of patient care, decrease the quality of patient care purchased by the government or involve the misapplication of government funds." *United States v. Zacher*, 586 F.2d 912, 916 (2d Cir. 1978).

especially in the assessment of prospective payment<sup>105</sup> and incentive plans.<sup>106</sup>

DRGs alone may cause the discharge of patients before adequate care is furnished.<sup>107</sup> Because most physicians have a financial stake in the continued existence of hospitals that have granted them staff privileges,<sup>108</sup> physicians are motivated to contain costs where feasible. Today, doctors treat most complicated procedures and serious illnesses in the hospital setting, often on an outpatient basis, rather than in the home or the physician's office.<sup>109</sup> Thus, the modern physician has a definite interest in keeping solvent the hospital that has granted him staff privileges. Physicians understand the potential financial effects of the DRGs upon their hospitals<sup>110</sup> and will, if possible, reduce ser-

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105. "[I]nstitutional responses to these incentives [of the DRG system] are likely to decrease costs per case and have a moderate chance of decreasing total health care costs, but are also likely to have deleterious effects on the quality of patient care and on access to care." Stern & Epstein, *supra* note 99, at 621; *see also* R. Rubin, in DRGs—What's Next? Two Views, *supra* note 26, at 8; Matsui, *supra* note 13. *But see* 1 PPS Hearing, *supra* note 4, at 30-31 (statement of Richard S. Schweiker, Secretary of Health and Human Servs.) (assuring that the PPS will allow continued commitment to high quality care and may enhance quality of care by encouraging hospital specialization).

106. The Department of Health and Human Services Regional Inspector General's investigation into the Hollywood Community Hospital incentive plan is, in part, focusing on the impact of the plan on quality of care, *see supra* note 36; Judicial Council, Report D, *supra* note 41. "DRG legislation was intended to eliminate waste and stimulate efficiency in hospital care without reducing the quality of health care. Arrangements by which physicians participate in reimbursements to hospitals, particularly where there are incentives that may adversely affect the quality of patient care, thwart the intent of the legislation." *Id.* at 176, reprinted in 253 J. A.M.A. 2425, 2425 (1985).

107. The results of a survey of state nursing home ombudsmen support this contention. Seventy-five percent of those ombudsmen responding said that "patients are discharged sicker or much sicker than before PPS." *Joint Hearing on Quality Health Care, supra* note 13, at 3-4 (survey submitted by Rep. Synar). *Medicare Crisis Hearing, supra* note 101, addresses the problem of premature discharge. *See also* 1 *Quality of Care Under Medicare's Prospective Payment System: Hearings Before the Senate Special Comm. on Aging*, 99th Cong., 1st Sess. (1985).

108. *See supra* note 30 and accompanying text.

109.

Of the some 142,000 active practitioners in the United States in 1929, about eight out of ten were affiliated with a hospital, and about one in twenty-five even had private offices or held hours for private patients in hospitals. By 1975 virtually no physician would consider practicing without the resources and consultants that hospital affiliation brought, and about one in four of the some 330,000 active American physicians practiced full-time in a hospital.

S. REISER, *MEDICINE AND THE REIGN OF TECHNOLOGY* 156 (1978) (footnote omitted).

110. *See, e.g.,* Angell, *Cost Containment and the Physician*, 254 J. A.M.A. 1203 (1985); Ellwood, *supra* note 8; Jessee & Suver, *supra* note 26; Johnson, *Life, Death, and the Dollar Sign: Medical Ethics and Cost Containment*, 252 J. A.M.A. 223 (1984); Mushlin, *supra* note 24; Stern & Epstein, *supra* note 99; Stone, *Law's Influence on Medicine and Medical Ethics*, 312 NEW ENG. J. MED. 309 (1985); Wennberg, McPherson & Caper, *supra* note 100; R. Rubin, in DRG's—What's Next? Two Views, *supra* note 26.

vices and treatment wherever possible, presumably without taking risks with patient health. Whether or not incentive plans are utilized, physicians will have the motive to cut back or contain costs in the manner they feel best.<sup>111</sup>

Incentive plans heighten physicians' motivation, induced by DRGs and prospective payment, to eliminate costs.<sup>112</sup> Thus, the plans magnify the threat to quality of care. Medical schools and residencies train physicians to be complete in caring for their patients.<sup>113</sup> An incentive plan, however, encourages physicians to disregard that training by rewarding most lucratively those physicians who provide patients the least amount of care<sup>114</sup> in the shortest period of time.<sup>115</sup>

Physicians themselves have reported concerns about the quality of care in relation to the DRG program. An informal, ongoing

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111. The potential threat of medical malpractice suits may discourage more severe cases of withholding or curtailment of care. "There is no question that the malpractice courts are enforcing a standard of care that, because it is drawn from existing practice, embodies many of the system's distortions and its lack of cost consciousness. One of the law's effects is to make any economizing move suspect . . ." Havighurst, *Competition in Health Services: Overview, Issues and Answers*, 34 VAND. L. REV. 1117, 1145 (1981). But "[p]otential tort liability is only an uncertain inducement to good quality performance because the likelihood is small that legal exposure will materialize from a caregiver's skimping on quality to save money." Kapp, *Legal and Ethical Implications of Health Care Reimbursement by Diagnosis Related Groups*, 12 LAW MED. & HEALTH CARE 245, 249 (1984).

For a discussion of the medical malpractice problems for physicians that arise because of financially motivated behavior under DRGs and incentive plans, see Chenen, *supra* note 31, at 134; Kapp, *supra*; Note, *Rethinking Medical Malpractice Law in Light of Medicare Cost-Cutting*, 98 HARV. L. REV. 1004 (1985); Comment, *supra* note 80; see also Jessee & Suver, *supra* note 26, at 6; Note, *Medicare's Prospective Payment System: Can Quality Care Survive?*, 69 IOWA L. REV. 1417, 1431-44 (1984) (arguing that medical malpractice law is inadequate to protect victims of cost containment). But see Mushlin, *supra* note 24, at 18:

Any alteration in practice patterns has the potential for either increasing or decreasing the quality of patient care. Curtailing unnecessary utilization should decrease morbidity and mortality through elimination of the risks of unneeded diagnostic or therapeutic efforts as well as via the reduction of errors in diagnosis resulting from unnecessary tests or procedures. If needed services are curtailed, however, the quality of care will be affected adversely.

Physicians making financially motivated patient care decisions may also be vulnerable to conflict of interest claims. Chenen, *supra* note 31, at 141; Comment, *supra* note 80, at 1032.

112. See *supra* notes 108-11 and accompanying text.

113. Lowenstein, Iezzoni & Moskowitz, *supra* note 42, at 2636 (citing Hardison, *To Be Complete*, 300 NEW ENG. J. MED. 193 (1979)).

114. More intensive care during a short length-of-stay will not necessarily ensure the physician a reward under an incentive plan. Because each test performed costs the hospital money, the more tests performed, the less available for distribution to physicians.

115. Although the PPS encourages this behavior by the hospital, incentive plans extend the motivation to the physician. Comment, *supra* note 80, at 1023-26 (discussing the malpractice issues that result from undertreatment).



AMA survey<sup>116</sup> reports that sixty-six percent of the physicians responding feel that quality of care has deteriorated since the implementation of DRGs.<sup>117</sup> Hospitals discourage physicians from immediately treating secondary conditions or complications because of the limitations on reimbursement.<sup>118</sup> In addition, physicians are concerned with the possible effects of early discharges on the health of their patients.<sup>119</sup> Finally, physicians feel "pressure" from hospital administrators to limit laboratory tests and procedures that may be necessary to proper diagnoses.<sup>120</sup> Because incentive plans increase the economic pressures that members of the medical profession already feel, the plans magnify the existing threat to the delivery of quality care.<sup>121</sup>

Incentive plans encourage physicians to put their financial interests and those of the hospital ahead of their ethical obligations to patients.<sup>122</sup> Because incentive plans encourage physi-

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116. The "Monitoring Project" was not designed as a "scientific" survey and is being used as an "information assessment activity to ascertain the current impact of the PPS and to identify possible 'problem' areas that might need further study." Report of the Am. Med. Ass'n Bd. of Trustees, AMA's DRG Monitoring Project and the Prospective Pricing System 6 (Dec. 1984) (copy on file with U. MICH. J.L. REF.); Report of the Am. Med. Ass'n Bd. of Trustees, AMA's DRG Monitoring Project and the Prospective Pricing System 5 (Dec. 1985) [hereinafter 1985 AMA Report] (copy on file with U. MICH. J.L. REF.).

117. 1985 AMA Report, *supra* note 116, at 6.

118. *Id.*

119. *Id.*

120. *Id.* at 6-7.

121. The General Accounting Office recently studied incentive plans and concluded that some plans encourage physicians to undertreat patients. See S. REP. No. 520, 99th Cong., 2d Sess. 26 (1986). The Senate Committee on Finance proposed an amendment to a recent House bill, H.R. 1868, 99th Cong., 2d Sess. (1986), to address this problem. This amendment would allow the Secretary of Health and Human Services to assess civil money penalties against a physician who underserves or fails to admit a Medicare patient due to projected length-of-stay or projected treatment costs. The penalty will only be imposed if the patient's health is adversely affected and the physician participates in an incentive plan that determines rewards by considering length-of-stay or treatment costs. The amendment would also provide for fines against hospitals offering such incentive plans if either the patient or the physician could be individually identified. *Id.* HMOs and similar cost-effective medical care organizations would be initially exempted from the amendment's coverage. *Id.* at 26-27.

The Senate Report, however, does not conclude that incentive plans violate the fraud and abuse provisions of the Medicare statute and so would not prohibit the use of all such plans. This Note would go further, finding that incentive plans do violate the fraud and abuse provisions and forbidding their use by hospitals. See *supra* Part II.

122. In one scholar's view, medical ethics are based on two maxims: "'do what you think will benefit the patient' and 'primum non nocere,' or first of all, do no harm." Stone, *supra* note 110, at 311. An interesting discussion of the ethical problems faced by physicians who engage in health care rationing can be found in Pellegrino, *Rationing Health Care: The Ethics of Medical Gatekeeping*, 2 J. CONTEMP. HEALTH L. & POL'y 23 (1986). See also Johnson, *supra* note 110 (discussing the ethical problems facing specialists in critical care).

cians to discharge patients as early as possible and minimize the use of ancillary services,<sup>123</sup> the plans may reward physicians for neglecting the obligation to provide the best possible treatment<sup>124</sup> by taking full advantage of all hospital resources. The sooner the physician discharges a patient, and the less care provided during the patient's stay,<sup>125</sup> the greater the potential profit in reimbursement for that patient's care. The greater the profit per patient, the greater the doctor's reward from an implemented incentive plan.

### CONCLUSION

This Note has argued that as a matter of both policy and statutory interpretation, incentive plans are not acceptable. The plans clearly violate the fraud and abuse provisions of the Medicare statute and thus constitute an improper means of maintaining hospital financial stability under the PPS. Congress explicitly stated in the Fraud and Abuse Amendments that any remuneration in return for referrals is prohibited. Those hospitals using incentive plans must reconsider their programs in light of potential prosecution and even felony convictions. Furthermore, the potential for decreased quality of care and increased DRG creep greatly diminishes the attractiveness of the incentive plans as a means of cost containment. By utilizing incentive plans, hospitals exacerbate the existing problems of fraud and abuse in the Medicare system.

Furthermore, courts, when confronting incentive plans in prosecutions under the Fraud and Abuse Amendments, should

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123. See *supra* notes 29-35 and accompanying text.

124.

It is one thing to entrust your life and health at times of crisis to a physician who is committed to the practical ethics that involve[] a quest for excellence and who may err on the side of doing too much. It is quite another to entrust your life and health at times of crisis to a physician whose diagnostic and therapeutic interventions are limited by new regulatory constraints or incentives of competitive efficiency that "place the provider at economic risk."

Stone, *supra* note 110, at 312; see A. SORKIN, *supra* note 14, at 89 (suggesting that incentives such as hospital office lease agreements, under which the number of patients the physician admits to the hospital determines the lease payments, may affect the independence of physicians' health care decisions).

125. "[P]hysicians remain the first line of defense against erosion in the quality of care. Although prospective payment will give hospitals an incentive to cut the number of tests or to reduce the length of stay, everyone is counting on physicians to assure that the patient is not endangered." R. Rubin, in DRG's—What's Next? Two Views, *supra* note 26, at 8; see also Jessee & Suver, *supra* note 26, at 4.

take the statutory language literally—finding those participating in such plans guilty of felonies—in order to ensure that health care providers honor the intent of Congress and that the elderly receive competent care. The elderly deserve comprehensive, high-quality care whenever medical care is indicated, not only when it is economical for hospitals and physicians to provide it. The courts must provide this assurance to the elderly by strictly interpreting the fraud and abuse statute and forbidding the use of incentive plans. The legislature forbade incentive plans through the fraud and abuse provisions of the Medicare Act. Now judicial and enforcement personnel must carry out that legislative directive.

Incentive, or profit-sharing, plans invite physicians to balance the quality of care against personal financial reward. That self-interest might outweigh excellence in care and influence medical judgment is surely an intolerable threat to the Medicare system.

—*Kathryn A. Krecke*

#### EDITOR'S POSTSCRIPT

Recent Congressional action supports the Notewriter's arguments against physician incentive plans. The Omnibus Budget Reconciliation Act of 1986 specifically outlaws payments "directly or indirectly, to a physician as an inducement to reduce or limit services" for Medicare patients.<sup>126</sup>

The Hollywood Community Hospital<sup>127</sup> has ended its physician incentive program in response to the new law.<sup>128</sup> The Department of Health and Human Services Regional Inspector General, who had been scrutinizing the hospital as a result of its implementation of the incentive program, has terminated his investigation.<sup>129</sup>

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126. Pub. L. No. 99-509, § 9313, 100 Stat. 2002, 2003 (1986).

127. See *supra* notes 32-37 and accompanying text.

128. Telephone interview with Donald Goldman, attorney for Hollywood Community Hospital (July 20, 1987).

129. *Id.*